Rectal prolapse: enlightenment of the obscure
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Future perspectives
Although with this thesis some light has been shattered upon the somewhat obscure scientific field concerning rectal prolapse surgery, many questions remain unanswered. This thesis has shown that internal rectal prolapse (IRP) is likely to precede external rectal prolapse (ERP) before it protrudes through the anus. We have only captured symptomatic patients with internal rectal prolapse though. It is a possibility that not all patients with a high-grade IRP will be symptomatic as normal volunteer studies suggest. Analysing patients with a defaecography randomly and operate on those with a radiologic high-grade IRP seem to be cutting the corners.

It is mandatory that the symptoms play the major role in the decision whether to operate or not. We now know which symptoms are associated with high-grade IRP (chapter 3). What we have shown is that about 85% of patients with high-grade IRP improve symptoms of obstructive defaecation and/or faecal incontinence after a laparoscopic ventral rectopexy (LVR). This indirectly proves the concept that IRP as part of the descending perineum syndrome actually causes symptoms of obstructive defaecation and faecal incontinence otherwise why would correcting the anatomy with a LVR improve these symptoms. More interesting is the remaining 15% who do not improve after LVR. Are these patients the presumed “asymptomatic” high-grade IRP patients with other functional disorders to cause their symptoms? This is a relevant question which needs to be answered as good as possible before the decision is made to operate. Thorough pre-operative analysis including an endo-anal ultrasonography, manometrie and a transit study (in case of obstructive defaecation) should be done to exclude other causes for functional complaints and provide a complete picture. This also gives us the opportunity for re-analysing the remaining 15% whose symptoms did not improve. Many remaining question can be easily answered. Did patients with faecal incontinence who did not respond to surgery have sphincter defects with significant pressure reduction? If so can a threshold be obtained? Is a reduction in rectal compliance associated with urge faecal incontinence? Are symptoms of obstructed defaecation and faecal incontinence affected evenly? Etcetera.

A second explanation could be that the surgical technique is shortcoming. A study with postoperative investigations (defaecography, manometrie, endo-anal ultrasonography and transit study) can probably answer this question. In my opinion the way the mesh is attached to the ventral rectal wall can be decisive. Should a douglasectomy be performed to allow a better fixation to the rectal wall? How tight should the mesh be attached to the promontory keeping in mind that polypropylene meshes will shrink significantly in time? Are light weight meshes as effective? A large (inter)national audit for functional colorectal surgery, at which all of the different data on symptoms, physiology and outcome of treatment is prospectively collected, will be of great value. What will the long-term results be of LVR for high-grade IRP and especially the long-term mesh related complications? In our series after a median follow up of 12 months no mesh related complications were observed. Mesh related complication after gynaecological transperineal procedures for urine stress incontinence has caused the FDA to question
the legitimacy of these procedures in the United States. Much of these complications were already noted after short duration follow-up (2 years) though. These techniques rather differ in aspect (apart from using a polypropylene mesh) and are therefore incomparable. Nonetheless it is not known what the long-term effects (and results) will be and it is important to have these results as soon as possible. Before the long-term results are known I believe it is mandatory to discuss this with the patient before operation. In this thesis no data is published on sexual function. Critics may interpret this as withholding negative side effects of LVR. The truth is that we did not study (implement it in our prospective database) sexual function after LVR yet. Our personal observation is that it actually seems to improve sexual function. A recently accepted paper to be published by Abet et al has confirmed this hypothesis.

For symptoms of obstructed defaecation the Wexner constipation score is used in this thesis. This constipation score is meant to be used for patients with constipation in general though and not specifically designed for symptoms of obstructive defaecation. Symptoms as seen in patients with slow transit constipation play a large role in this scoring system. When patients with high-grade IRP are identified differentiation between symptoms of slow transit constipation (hard stool, reduced frequency of stool, bloating, and abdominal pain) and obstructive defaecation is mandatory. A better score designed for symptoms of obstructed defaecation is the Altomare ODS score. This score is far from perfect though and symptoms of slow transit constipation are still included such as stool consistency and the use of laxatives and or enemas whereas in patients with obstructive defaecation a prominent observation is that often symptoms of obstructed defaecation remain despite normal consistency of stool.

More importantly faecal incontinence is not included in the Altomare ODS score at all. A phenomenon often seen in patients with high-grade IRP, with both symptoms of obstructive defaecation and faecal incontinence, is that when the stool is medically softened (with laxatives) symptoms of faecal incontinence are predominant whereas if the stool is medically hardened (with loperamide syrup) symptoms of obstructive defaecation become predominant. When research is done on which symptoms (as described in Chapter 3) respond well after LVR a better scoring system can be developed. If validated as well it is likely that a better prognosis of outcome of surgery can be obtained.

Clearly more research is needed to fully understand rectal prolapse and its pathophysiology (especially IRP). It is an interesting and dynamic field of research. Laparoscopic ventral rectopexy, with good functional outcome and low introduction of morbidity, seems to act as a catalyst. As more pieces of the puzzle are becoming available a more clear view on rectal prolapse will emerge.
References

1. FDA Safety Communication: UPDATE on Serious Complications Associated with Transvaginal Placement of Surgical Mesh for Pelvic Organ Prolapse (www.fda.gov)

